Public Comments to the Development of a Blue Print for Integration of Acute and Long Term Care Services
October 18, 2006

Good morning and thank you for the opportunity to address the development of a blueprint for the integration of acute and long-term services. I am Keren Ellis a Regional Administrator for Professional Healthcare Resources, a Medicaid and Medicare home health and personal care provider here in Richmond and the Vice President of the Virginia Assocation for Home Care and Hospice, chair of the legislative committee, and a registered nurse.

As an organization we recognize that there is tremendous pressure on both our Medicare and Medicaid systems to constrain the cost of the programs. As providers we also recognize that those cost restraints can have an adverse impact on our industry. These two factors are compounded by the fact that Virginia's Medicaid program is one of the most conservative programs from both a beneficiary and provider perspective leaving little room for cost savings or budget trimming.

VAHC recognizes that our system is in need of reform but not at the cost of patient care. Without a strong home health care industry in Virginia patients cannot receive the quality of care that they deserve. Any type of integrated acute and long-term care must be based on uniform quality standards and not solely on the construct of saving program dollars.

I want to tell you a little bit about our transition to Medicare managed care from a home health perspective in the hopes that there can be some lessons learned. Prior to this past year there was little to no Medicare managed care in Virginia. Wholesale reforms created by the Medicare Modernization Act created a paradigm shift in our Medicare system, which was based on managed care. The transition took place in concert with the new prescription drug benefit and resulted in a significant passive enrollment. Medicare beneficiaries thought they were in traditional Medicare and they were not. They had unknowingly been enrolled in a managed care plan. Many of their home health benefits had changed, in some cases significantly. From a provider perspective, we received no training from the wide array of new Medicare managed care plans on preauthorizations or billing procedures. Providers carried large receivables for many months not knowing when, or even if, they would be paid for services that had already been delivered. Cash flow is a vital component of the home health business model.

Systems were not in place nor do they adequately exist 12 months later. Managed care organizations did not, and still do not, understand the home health model. How we deliver services, our patients, or our systems and there has been little to no effort on their part to gain this knowledge. We as providers continue to struggle in the Medicare managed care environment with only six percent of beneficiaries enrolled in managed care.

Medicaid rates for home health are low. Medicaid rates for personal care are 40% below national averages. Any attempts to down-stream risk will result in a failed program. Providers can not absorb any additional cost

cutting schemes as they apply to either Medicare or Medicaid. Data from 2004 indicates that one-third of Virginia's Medicare home health care agencies have margins of less than 0. The balance between Medicare and Medicaid is in poor health itself. Any system transformation must be taken slowly to minimize any potential negative outcomes.

Home health and personal care services are one of the few bridges between hospitalization and independence. A recent study published in the Journal of American Geriatrics Society concluded that older adults who do not have help with activities of daily living, such as dressing and bathing are much more likely to be hospitalized for acute illness than adults who receive the personal care help that they need. Evidence exists of those older adults who qualify for nursing home care due to disabilities in activities of daily living can continue to live in their homes provided they receive personal care assistance. Thus home health and personal care services can serve as the bridge between the acute care and long-term care models of care. According to the June 2006 MedPac Report to Congress, integrating the use of nurse care managers and information technology in the clinical care of patients with high-cost, complex needs has the potential to improve quality and reduce costs in our health care system. The report also notes increased hospitalization is attributed to poor monitoring of treatment between physician visits and the lack of communications among providers.

Home health offers a great degree of care coordination and nursing interventions coupled with new technology. This is a great opportunity to

create additional efficiencies in our health care system as it pertains to both our aging and disabled populations.

Recommended Home Health and Personal Care
Core Benefits for Special Needs Plans
10/18/06

Blue Print for the Integration of Long-term and Acute Care

- Fair and equal access
- Beneficiary coverage that accurately reflects the needs of the patient based on clinical nursing evaluations
- No less than current Medicaid rates for skilled services
- Personal care rates that reflect the cost of services, $17.08 per hour
- Skilled home health care episode payment
- Specific billing codes utilized under a fee for services reimbursement system
- Clear billing requirements
- 30 day prompt payment for clean claims
- Built in market basket inflation index for skilled home health and personal care services
- Preset authorized visits per diagnosis
- Online authorization, benefit determination/eligibility and claim status
- Easy access to a live knowledgeable person to address provider issues
- Electronic billing, fund transfers and remittance advice
- No additional information required with billing such as notes
- No co-pays for patients
- Health promotion and illness prevention
- Home health chronic disease reimbursement model
- Utilize the Medicaid home bound criteria for skilled home health
- Modifications to the current personal care eligibility criteria that are lower than current requirements
- Coverage that more accurately reflects the needs of the individual based on clinical nursing evaluations
- Inclusion of telehealth technologies that are reimbursable as a part of home health benefits
- Infusion carve-out if supplies are bundled in the payment
- Carve-out for ostomy supplies for pre-existing conditions
- Hospice benefit as a carve-out

- Personal care services provided within current DMAS manual standards
- Well defined care management that utilizes home health
- Consumer outreach, education and advocacy
- Provider complaint resolutions process
- Ombudsman program for beneficiaries
- Patient choice